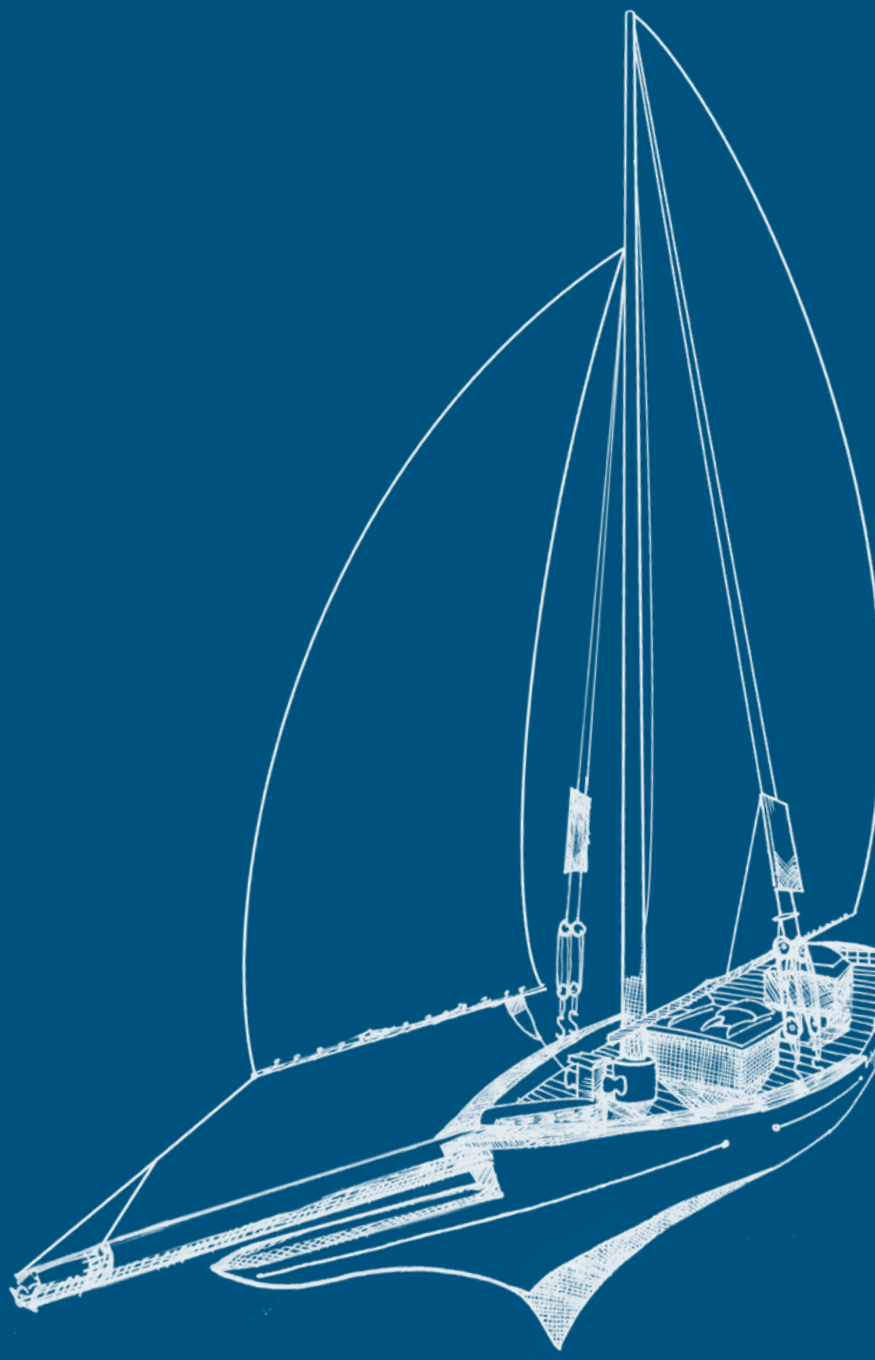

Measuring the Quality of Maryland HMOs and POS Plans

2006/2007 CONSUMER GUIDE

MHCC
MARYLAND
HEALTH CARE
COMMISSION

Cover *The Skipjack shown on the cover is the state boat of Maryland. Designed for dredging oysters from shallow water, Maryland has committed to preserve the Chesapeake Bay skipjack fleet because of its historic and early economic importance to the state. Today, only a few remain and represent the last working boats under sail in North America.*

Measuring the Quality of Maryland HMOs and POS Plans: 2006/2007 Consumer Guide is published by the Maryland Health Care Commission.
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-3460; Fax: 410-358-1236; Toll-Free: 877-245-1762; TDD: 800-735-2258
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ABOUT THIS GUIDE

Choosing your health plan is an important decision. Because not all health plans are the same, the one you select can make a difference in the quality of your health care. *Measuring the Quality of Maryland HMOs and POS Plans: 2006/2007 Consumer Guide* compares measures of quality care that managed care plans in Maryland provide to their members. The information in this Guide will help you choose a health plan that works best for you, especially when used to complement cost and benefit information given to you by your employer or health plan.

Be an informed consumer when it comes to your health care!

USE THIS GUIDE AS A TOOL TO

- Learn more about how health insurance works and compare measures of quality care that plans provide to their members.
- Make the best use of your health plan. See how your plan compares to others in Maryland.

INFORMATION IN THIS GUIDE INCLUDES

- Health Maintenance Organizations (HMOs) and Point of Service (POS) plans available in Maryland and their contact information
- Steps to guide you in choosing a health plan
- An explanation of what plan quality means and its importance
- Plan members' survey responses about their health plan and services they receive
- Plans' performance on providing important health care services, tests, and treatments
- Who to contact if you disagree with your plan's decision to limit or deny services to you

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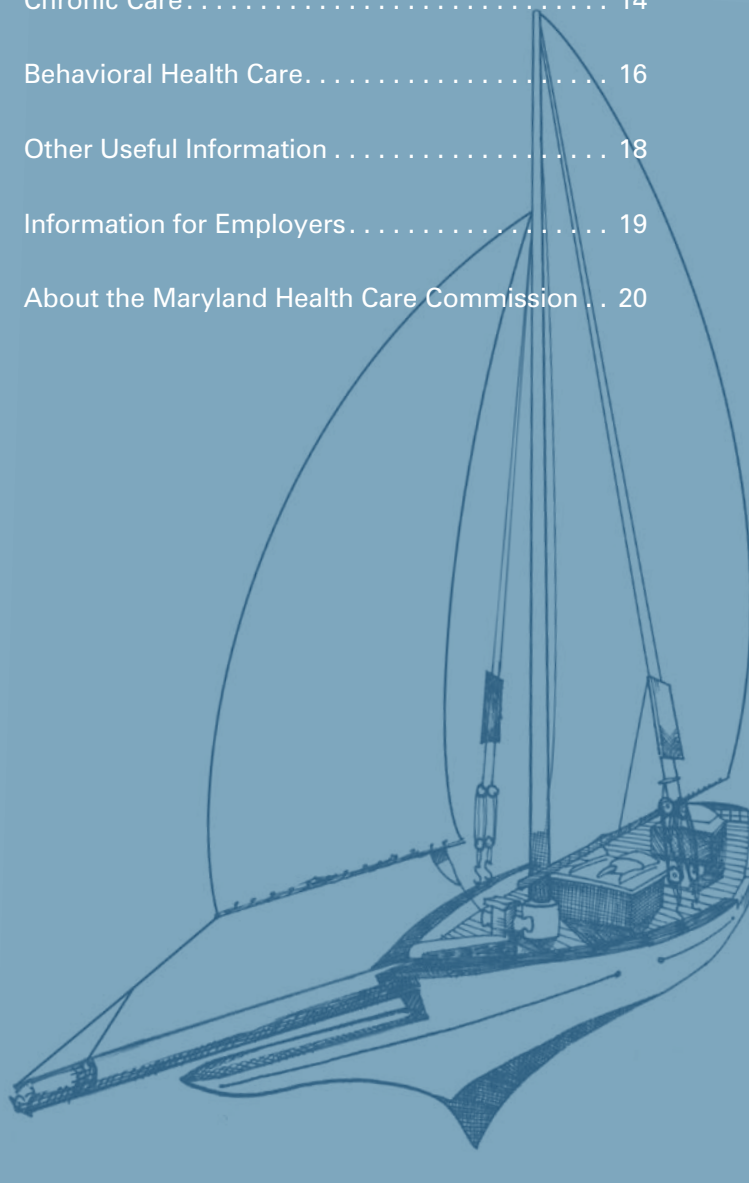


Managed Care in Maryland

MARYLAND HEALTH PLANS IN THIS GUIDE

This Guide reports on HMOs and POS plans available to Maryland employers and their employees. The table below gives you some important information about each plan. See page 4 for tips on how to use this information when choosing a health plan.

Health Plan Accreditation

Accreditation is a way of assessing health plan quality. It lets you know that an independent organization has checked how well a health plan provides the health services you need. All plans listed in this Guide are accredited by the National Committee for Quality Assurance (**www.ncqa.org**) or by the American Accreditation Healthcare Commission (**www.urac.org**).

PLAN SUMMARY INFORMATION

Health Plan	Plan Service Areas Each Maryland region is described below				
	Baltimore Metro Area	Washington D.C. Metro Area	Eastern Shore	Southern Maryland	Western Maryland
Aetna Health Inc.— Maryland, DC and Virginia (Aetna)	✔	✔	Cecil, Kent, Queen Anne's Talbot, Wicomico	✔	Frederick, Washington
	Northern Virginia, Richmond, Roanoke, Hampton Roads				
Carefirst BlueChoice, Inc. (BlueChoice)[a]	✔	✔	✔	✔	✔
	Northern Virginia				
CIGNA HealthCare Mid-Atlantic, Inc. (CIGNA)	✔	✔	✔	✔	✔
	Virginia				
Coventry Health Care of Delaware, Inc. (Coventry)	✔	✔	✔	✔	Allegheny, Frederick, Washington Garrett
	Delaware, Southern New Jersey, Southeastern Pennsylvania				
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente)[b]	✔	✔	N/A	Calvert, Charles	Frederick
	Northern Virginia				
MD-Individual Practice Association, Inc. (M.D. IPA)[c]	✔	✔	✔	✔	✔
	Washington D.C., Virginia				
Optimum Choice, Inc. (OCI)[c]	✔	✔	✔	✔	✔
	Washington D.C., Virginia, Delaware, West Virginia				

[a]BlueChoice, a for-profit HMO, operates under a holding company called CareFirst.
[b]Kaiser Permanente's performance in this Guide relates to HMO members only. It is the only non-profit HMO operating in Maryland.
[c]Two for-profit HMOs, M.D. IPA and OCI, are owned and operated by Mid-Atlantic Medical Services, LLC. (MAMSI), a regional holding company and subsidiary of UnitedHealthGroup, Inc.

Plan Service Area and Contact Information

The table lists the plans' service areas and contact information. Use it to:

- Find a plan where you live or work.
- Get more information directly from the plan's customer service department or visit its Web site.

Number of Plan Members

The table shows the total number of members enrolled in each plan, the percentage of members who enrolled in the plan's HMO product, and the percentage of members who enrolled in the plan's POS product.

Customer Service Information	Enrollment		
	Total Number of Plan Members	% of Members Enrolled in HMO	% of Members Enrolled in POS
800-323-9930 8:00am–6:00pm, Monday–Friday www.aetna.com	312,769	86%	14%
866-520-6099 • 8:00am–6:00pm, Monday–Friday 9:00am–2:00pm, Saturday www.carefirst.com	560,134	57%	43%
800-832-3211 • 8:00am–5:00pm, Monday–Friday www.cigna.com	279,805	66%	34%
800-833-7423 8:00am–5:00pm, Monday–Friday www.chcde.com	98,903	88%	12%
800-777-7902 or 301-468-6000 For the hearing and speech impaired: 301-879-6380 7:30am–5:30pm, Monday–Friday www.kaiserpermanente.org	443,566	96%	4%
800-709-7604, 24 Hours, 7 Days www.MamsiUnitedHealthcare.com	234,488	85%	15%
800-709-7604, 24 Hours, 7 Days www.MamsiUnitedHealthcare.com	504,786	85%	15%

Regions
Baltimore Metropolitan Area: Baltimore City, Baltimore, Carroll, Harford, Howard, Anne Arundel
Washington D.C. Metropolitan Area: Montgomery, Prince George's
Eastern Shore: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester
Southern Maryland: Calvert, Charles, St. Mary's
Western Maryland: Allegany, Frederick, Garrett, Washington

Steps to Choosing a Health Plan

STEP 1: DECIDE WHAT MATTERS TO YOU MOST. SOME IMPORTANT THINGS TO THINK ABOUT ARE:

- Choice of providers.
  Decide if you prefer few limits on your choice of providers or if you think you will have enough choices using the group of providers working with the plan (known as "in-network"). POS plans give you the option of seeing doctors outside of the plan's group of doctors.

> ***A Note About POS Plans…***
> *Though POS plans expand your choice of doctors through their out-of-network services, usually there is higher cost to use them. With a POS plan, you may have to pay higher fees (deductible, coinsurance, or co-payment) each time you see an out-of-network doctor. You might also have to pay more for your prescription drugs and pay higher premiums.*

- Easy access to care and a range of services that you need.
  If you have specific needs for medical or behavioral health care, you should use information from your employer, health plan, and this Guide to decide if the plan covers the services you will need by giving you enough choices of doctors, convenient locations, and quality care.
- Members' satisfaction with the plan. (see pages 6–9 for information)
- Learn what activities the plan has to help you and your family stay healthy.
  HMO plans make an effort to "manage" your care by designing programs that are intended to promote health and prevent illnesses. Read the *Manage Your Health Care* sections in this Guide (pages 10–17) to learn what activities Maryland plans have in place to "manage" plan members' care.*

**Each program highlight is an example of how the health plan attempts to improve the quality of care delivered to its members. It does not represent an endorsement of the plan. Other health plans may have a similar program.*

STEP 2: REVIEW THE RESULTS ON PAGES 10–17 TO COMPARE PLAN PERFORMANCE AND MEMBER SATISFACTION.

This Guide gives you results of how each plan did in both of these areas.

STEP 3: SELECT A PLAN.

When you have finished Steps 1 and 2, use the information to complement cost information from your employer or the health plans.

> ***How to Enroll in a Maryland Health Plan…***
> *There are two different ways to get health insurance. You can enroll in a health plan offered by your employer or you can purchase individual coverage ("individual" means the insurance is not obtained through an employer).*
>
> - *Employer coverage. There are two times when you can enroll in a health plan through your employer. The first is when you are newly hired and you enroll in a plan for the first time; the second is during an "open enrollment period" that happens once a year. In open enrollment, you can choose a different health plan or cancel your existing plan. Visit the human resources office where you work to find out when your open enrollment period is, what paperwork you need to fill out, and any other steps you need to take.*
> - *Individual coverage. To find out whether the plans listed in this Guide offer coverage directly to individuals and to get enrollment information, contact the plan's customer service department. See page 3 for contact information.*

Health Plan Quality Measurement

ABOUT HEALTH PLAN QUALITY

Health plan quality is important because when your plan offers the best possible care, you are more likely to get the best possible results. This Guide covers some quality measures that are important for you to know about when selecting a health plan. It is not possible to measure *everything* about a health plan, but this Guide will give you a lot of useful information. Two main types of nationally accepted quality measures used here can help you decide whether you are getting quality health care; the first evaluates member experiences and the second evaluates service results. Health plans report their evaluation of health care service results and an independent organization verifies that the information is correct.

DATA SOURCES

Maryland plans gathered information from their records and members and reported it to the state for this Guide.

Member Survey: This symbol means that information was gathered from health plan members using a survey that asked about their experiences with the plan. An independent company hired by Maryland conducted the survey of 1,100 members from each plan.[a]

Health Plan Records: This symbol means that the information was gathered from plans' records using a uniform system for collecting and reporting clinical information. All plans gathered information in the same way and an independent company hired by Maryland checked their methods for accuracy.[b]

The scores for every plan include the combined data for HMO and POS members, except Kaiser Permanente, whose ratings show HMO data only.

SUMMARY OF PLANS' PERFORMANCE

Above-average scores for all of the areas measured are added together to give a snapshot of each plan's high performance for 2006 and 2004–2006 (Star Performer).[c]

HEALTH PLAN	NUMBER OF TIMES ABOVE AVERAGE	NUMBER OF TIMES STAR PERFORMER
Aetna	3	0
BlueChoice	4	1
CIGNA	4	2
Coventry	4	4
Kaiser Permanente	9	5
MD IPA	6	3
OCI	3	0

LOOK FOR THESE SYMBOLS

★★★★ This symbol stands for *Star Performer*. It means that the plan's performance was better than the Maryland average for three years in a row (2004–2006).

★★★ This symbol means that the plan's performance was better than the 2006 Maryland average.

★★ This symbol means that the plan's performance was equal to the 2006 Maryland average.

★ This symbol means that the plan's performance was worse than the 2006 Maryland average.

[a] The survey is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 3.0H. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[b] Health plans report data using a system called the Health Plan Employer Data and Information Set (HEDIS®). HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[c] Health plans get a Star Performer designation on measures in this Guide for which they demonstrate high performance for three years in a row.

Members' Satisfaction with Their Health Plan

MEMBER OPINIONS MAKE QUALITY CHANGES HAPPEN

What members think about the service they get from their health plans and the care given by their doctors is important for improving the quality of care for everyone. Health plans use the comments to identify the need for new services and to improve the services already offered to give you the best care possible. Just as important, you likely want to know if members had good or bad experiences with the plan or its doctors.

Where does this information come from? A group of randomly selected members from each health plan answered questions sent to them in a survey. Their answers, as a group, are shown on the next page for each plan.

Manage Your Health Care—How CareFirst BlueChoice Uses Member Feedback to Improve Customer Services

CareFirst BlueChoice introduced the "First-Call Resolution" program in 2004. The program's goal is to quickly address member concerns and provide accurate information so that members do not have to call back a second time. Surveys of BlueChoice members show improvement in first-call resolution.

BlueChoice reviewed its service processes and tools to learn where it could make changes. As a result, BlueChoice

- Provides "Customer Experience Training" for customer service representatives.
- Installed new tools to help customer service representatives access member information.
- Increased the number of customer service representatives available to help members.

The customer satisfaction survey used to measure health plan quality asks about members' experiences with the plan's customer service. Survey data from 2006 show an increase of seven percentage points (from 2004) in the proportion of members who reported that they had no problems getting help from customer service.

This program is an example of how CareFirst BlueChoice sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.

The charts on this page summarize how members rated the services they received. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Member Survey

Performance

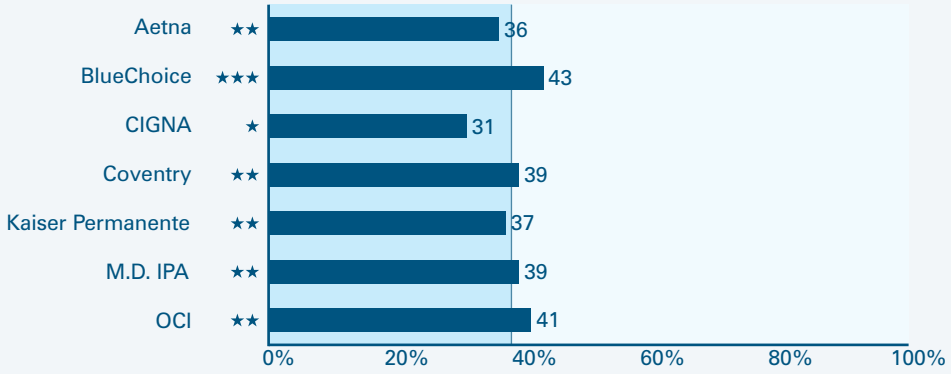
★★★★ Star Performer: Above Average for three years (2004–2006)
★★★ Above Average in 2006
★★ Average in 2006
★ Below Average in 2006

Stars show statistically significant differences between each plan's score and the Maryland average. "Statistically significant" means scores varied by more than could be accounted for by chance.

Rating of Health Plan

The percentage of members who rated their health plan "9 or 10" on a scale of 0–10, with 10 being the "best health plan possible."

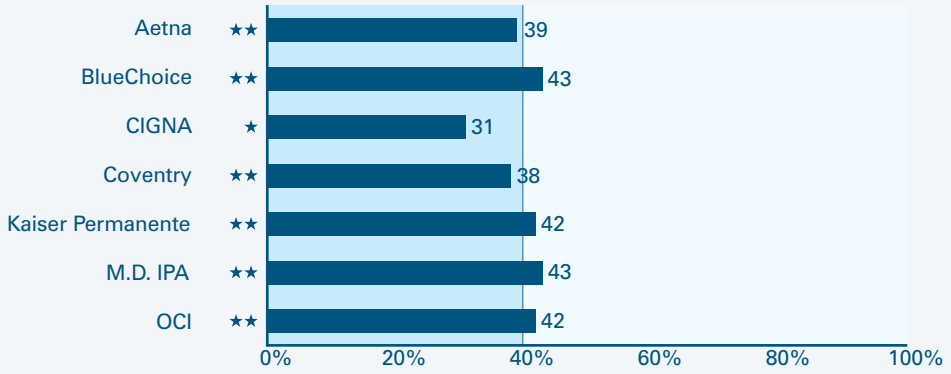
☐ MD Plan Average = 38%



Recommending Plan to Friends/Family

The percentage of members who said "definitely yes" when asked about whether they would recommend their health plan to friends or family.

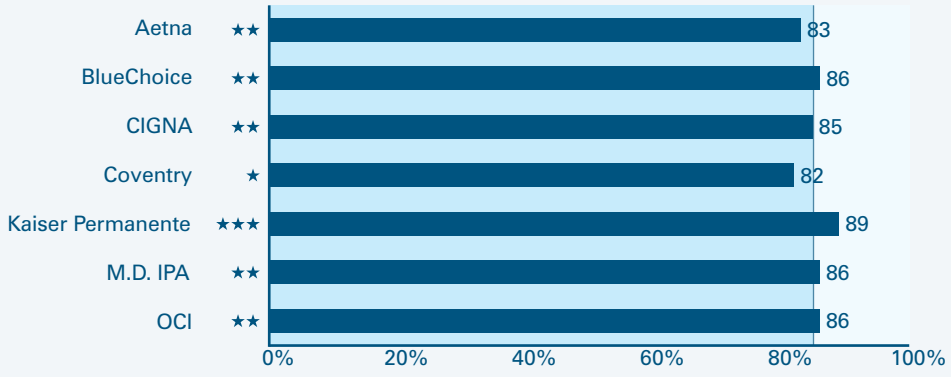
☐ MD Plan Average = 40%



Few Consumer Complaints

The percentage of members who said they "did not call or write their health plan with a complaint or problem."

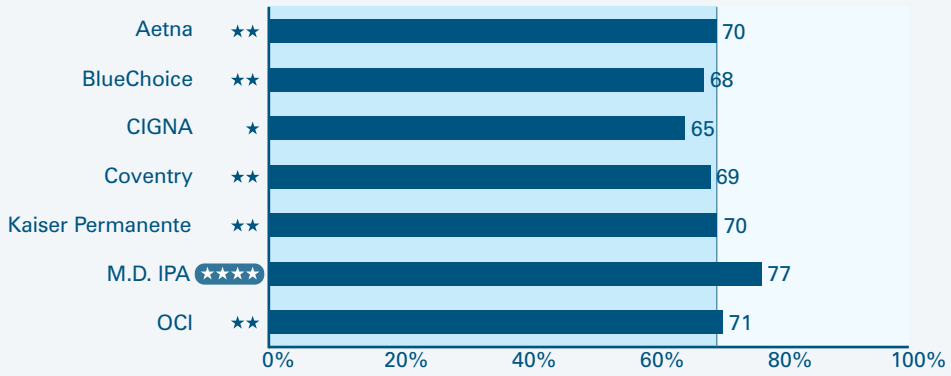
☐ MD Plan Average = 85%



Health Plan Customer Service

The percentage of members who said it was "not a problem" finding or understanding their plan's information, getting help from their plan's customer service department, and filling out paperwork.

☐ MD Plan Average = 70%



Members' Satisfaction with Getting Care

MEMBERS GRADE THE CARE THEY GET

Each year, Americans spend more for health care. Recently, U. S. health care spending reached $1.9 trillion. For the money you and your employer spend, does the quality of the care and services provide you with good value? Getting the right care is a good start to getting value for your health care dollars. That means seeing your doctor for check-ups, following the plan of care recommended for you, and using your primary doctor to coordinate tests and visits to other doctors. By using referrals from your doctor or health plan, you will save money, too, from lower copays and by using the best source for the care you need. For example, if you become sick or hurt when your doctor cannot see you, he or she may refer you to an urgent care clinic rather than a hospital emergency department. Going to an urgent care clinic should reduce the amount of time you wait and the amount of money you pay.

Where does this information come from? A group of randomly selected members from each health plan answered questions sent to them in a survey. Their answers, as a group, are shown on the next page for each plan.

Manage Your Health Care—How Coventry Uses Member Feedback to Improve Member Satisfaction

Member satisfaction is very important to Coventry. Every year, Coventry conducts a survey to get the opinion of members about how satisfied they are with their health plan and the care they get. The survey asks members to rate their doctor, their health plan, and the customer service they get, among other things.

Coventry uses the information it gets from members to identify areas that need changes and to create programs aimed at improving member satisfaction. Examples of this are:

- After members expressed dissatisfaction with the Customer Service Interactive Voice Response (IVR) telephone system, Coventry resolved this problem by providing members with the option to speak to a person when they call the customer service line instead of using the automated IVR telephone system.
- Doctors and other providers now receive training about nuclear medicine imaging (this includes X-rays, CT scans, MRIs, and ultrasounds) to learn ways to make sure that patients receive the appropriate types of testing and receive them on time.

In addition to the member survey, Coventry also gets member feedback through items that it publishes in the member newsletter, *Living Well*. Coventry's Quality Improvement Department reviews this feedback to identify any other issues that members may be experiencing and find ways to resolve them.

This program is an example of how Coventry sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.

The charts on this page summarize how members view their health care and how easy it is for them to get care. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Member Survey

Performance

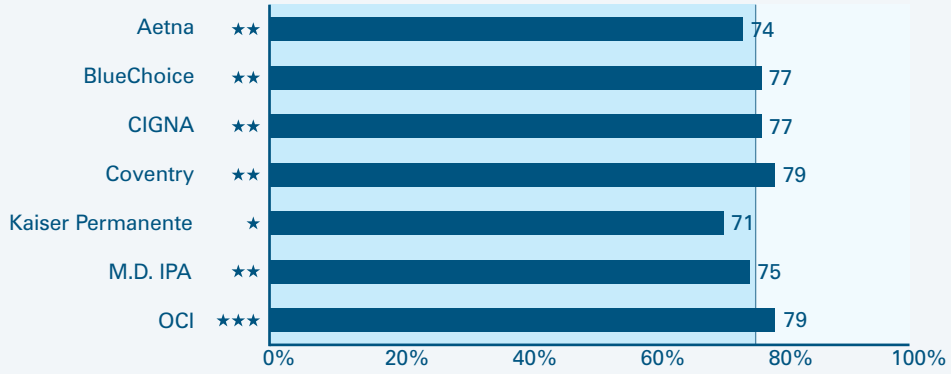
★★★★ Star Performer: Above Average for three years (2004–2006)
★★★ Above Average in 2006
★★ Average in 2006
★ Below Average in 2006

Stars show statistically significant differences between each plan's score and the Maryland average. "Statistically significant" means scores varied by more than could be accounted for by chance.

Getting Needed Care

The percentage of members who said it was "not a problem" choosing a personal doctor or nurse, seeing a specialist, getting necessary care, and getting quick approval for care.

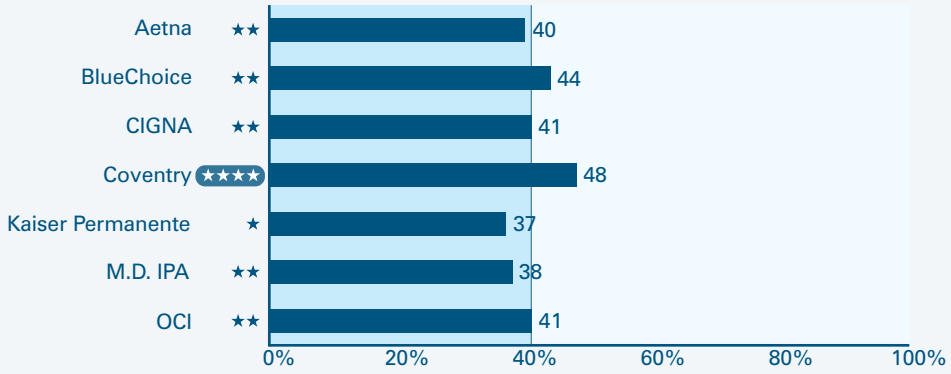
☐ MD Plan Average = 76%



Getting Care Quickly

The percentage of members who said they "always" got help when they called their doctor during office hours, got needed care for illness or injury when they wanted, got timely appointments for routine care, and waited no longer than 15 minutes past their appointment time.

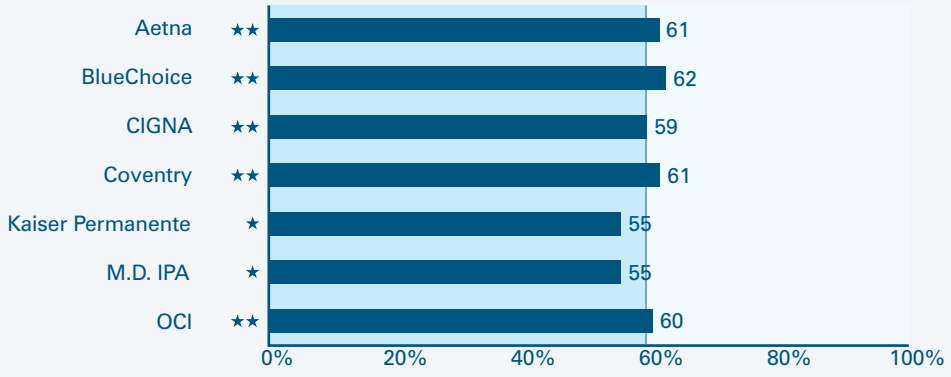
☐ MD Plan Average = 41%



How Well Doctors Communicate

The percentage of members who said that their provider "always" listened to them, explained things clearly, showed them respect, and spent enough time with them.

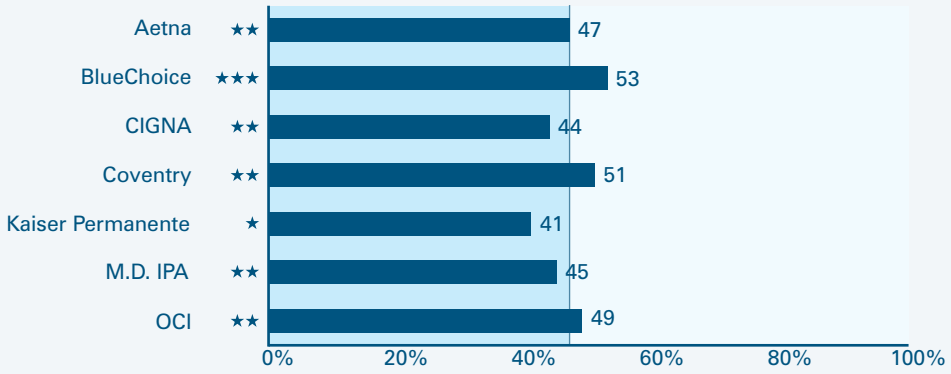
☐ MD Plan Average = 59%



Rating of Health Care

The percentage of members who rated their overall care "9 or 10" on a scale of 0–10, with 10 being the "best health care possible."

☐ MD Plan Average = 47%



Children's Health

BABY STEPS TO A HEALTHY LIFE

Every baby follows its own path in developing movement (motor) skills and relating to the world. How and when your child reaches milestone during the first two years will vary. Your baby's doctor is a good source to help you decide when a variation might be a cause for concern. The American Academy of Pediatrics recommends six well-child visits in the first year of life: the first within the first month of life, and then at around 2, 4, 6, 9, and 12 months of age. Regular check-ups for children during the early teen years can make parents aware of physical, emotional, behavioral, and social problems.

Health plans are rated on how well they provide preventive services—such as immunizations and regular check-ups—to children and adolescents. Most immunizations are given by the time children become 2 years old, but others are given during adolescence. For example, shots are given by age 13 to protect against hepatitis B.

Where does this information come from? For this group of members, each health plan checked its records to see which members received recommended care. For instance, did each child get the recommended check-ups and vaccines that prevent polio and other childhood diseases?

Managing Your Health Care—How CIGNA Works with Parents to Keep Kids on Track

CIGNA conducts outreach to parents to promote timely childhood and adolescent immunizations and to encourage regular well-child exams. CIGNA sends health information and a schedule for immunizations at birth and at 18 months, reminding parents to work with their child's doctor to complete immunizations by the time their child is 2 years old.

In addition, reminders are sent to the parents of children turning 12 years old, advising them of the current recommendations for adolescent immunizations. The reminders encourage parents to follow up with their child's doctor.

CIGNA has created programs addressing children's health for many years. Its current initiative began in 2004. Between 2002 and 2005, the number of fully immunized 2-year-old CIGNA members in Maryland increased from 78 percent to 85 percent and the number of adolescent members who received recommended vaccines increased from 30 percent to 55 percent.

This program is an example of how CIGNA sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.

The charts on this page summarize how plans provided children with important preventive care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

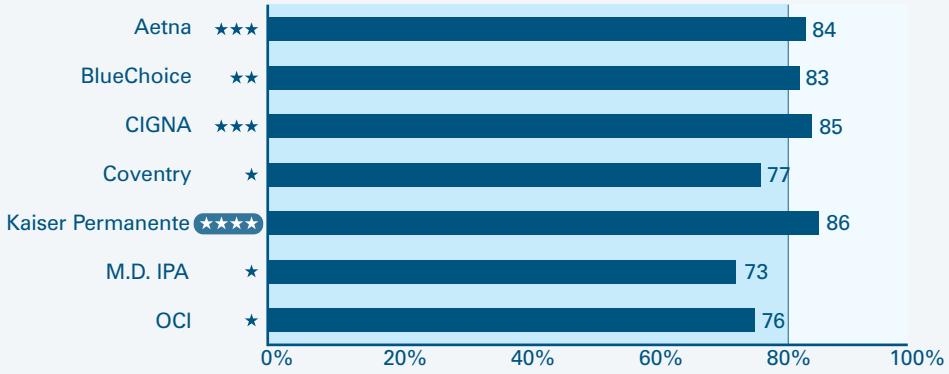
Performance

★★★★ Star Performer: Above Average for three years (2004–2006)
★★★ Above Average in 2006
★★ Average in 2006
★ Below Average in 2006

Stars show statistically significant differences between each plan's score and the Maryland average. "Statistically significant" means scores varied by more than could be accounted for by chance.

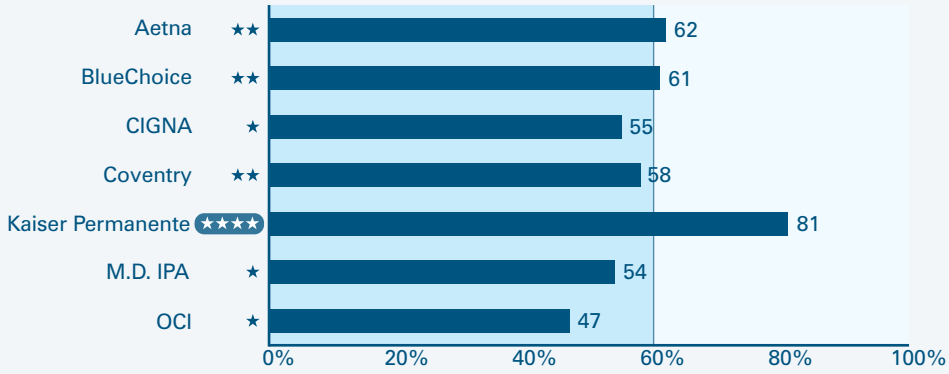
Immunizations for Children
The percentage of children who received vaccines for measles, mumps and rubella (MMR); polio; influenza (flu) type b; hepatitis B; chicken pox (VZV); and diphtheria, tetanus, and pertussis (DTaP/DT) by age two.

☐ MD Plan Average = 81%



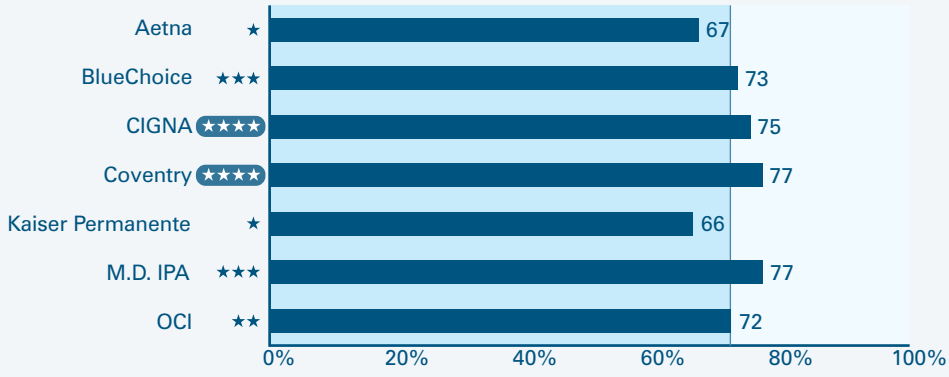
Immunizations for Adolescents
The percentage of adolescents who received vaccines for MMR, hepatitis B, and chicken pox by age 13.

☐ MD Plan Average = 60%



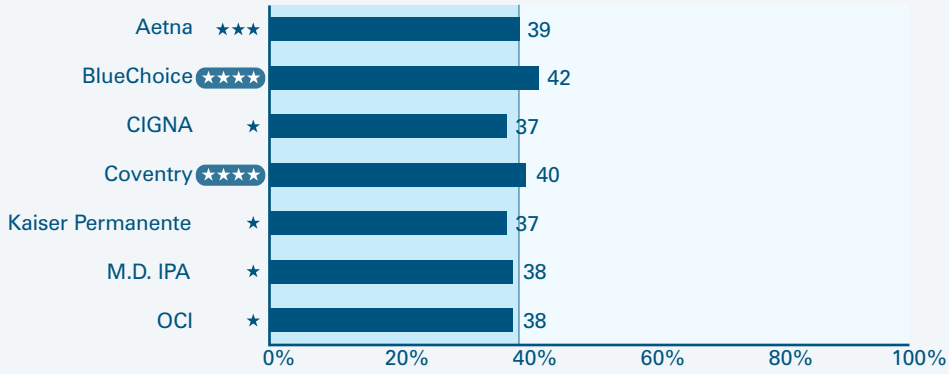
Well-Child Visits for Infants and Children
The combined percentages of infants who had six or more visits by age 15 months and children ages 3–6 years who had at least one visit to a primary care provider during 2005.

☐ MD Plan Average = 72%



Well-Care Visits for Adolescents
The percentage of adolescents ages 12–21 who had at least one visit to a primary care provider during 2005.

☐ MD Plan Average = 39%



Preventive Care

PREVENTION—A KEY TO HEALTHY LIVING

Preventing diseases or detecting them early keeps you healthy. Breast cancer screening is one example of a preventive service that health plans provide. When breast cancer is caught early, women have less of a chance of needing surgery and a better chance for survival. Women should start getting breast cancer screening from age 40 (or from a younger age, for women with high risk).

In Maryland, the National Breast and Cervical Cancer Early Detection Program provides breast cancer screening to low-income women. For more information about this program, call 800-477-9774 or visit **www.fha.state.md.us/cancer/html/bc_scrn.html**

Health plans rate differently on how well they provide their members with various preventive care services. The data on the next page show how well health plans performed in different preventive care areas in 2005. Information like this can help health plans decide which preventive services they need to improve.

Where does this information come from? For this group of members, each health plan checked its records to examine which members got the recommended screening service; for example, whether women age 50 and older got breast cancer screening at least once during 2004 or 2005.

Managing Your Health Care—How Kaiser Permanente Improved Colorectal Cancer Screening for its Members

Kaiser Permanente decided to improve its colorectal cancer screening program after reviewing the 2005 results. The plan decided to create a new telephone outreach program, using interactive voice technology, to educate members on the importance of colorectal cancer screening, to identify and address barriers that prevent some people from getting the screening, and to encourage follow up with members' physicians after screening. The program also allowed members to request home test kits for detecting blood in the stool. The presence of blood in the stool is a symptom of colorectal cancer, as well as other factors, so members with this result are asked to have further tests, such as a colonoscopy.

The first telephone calls to members began in October 2005 and ended in December 2005. Members between the ages of 50–80 were contacted, regardless of the length of their enrollment.

Fifty percent of members (9,600 people) who completed the call asked for a home test kit, and approximately 16 percent of those members returned their kits for analysis, as instructed. The 2006 colorectal cancer screening results for Kaiser Permanente showed that the number of members who were screened increased from 50 percent to 53 percent.

This program is an example of how Kaiser Permanente sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.

The charts on this page summarize how well plans provided their adult members with important preventive services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

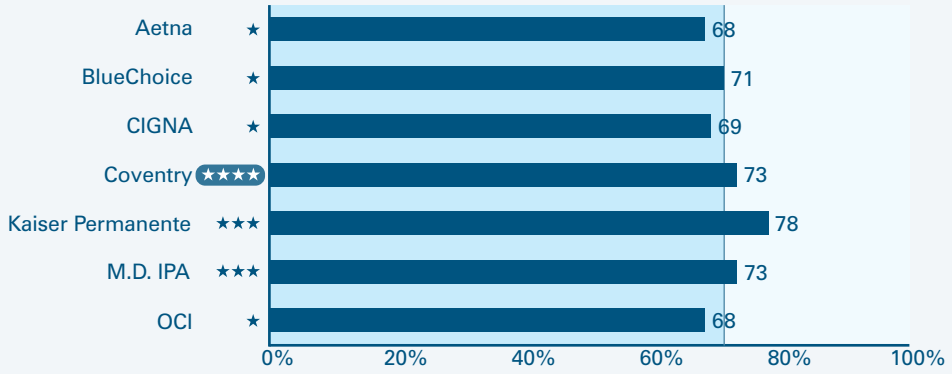
Performance

★★★★ Star Performer: Above Average for three years (2004–2006)
★★★ Above Average in 2006
★★ Average in 2006
★ Below Average in 2006

Stars show statistically significant differences between each plan's score and the Maryland average. "Statistically significant" means scores varied by more than could be accounted for by chance.

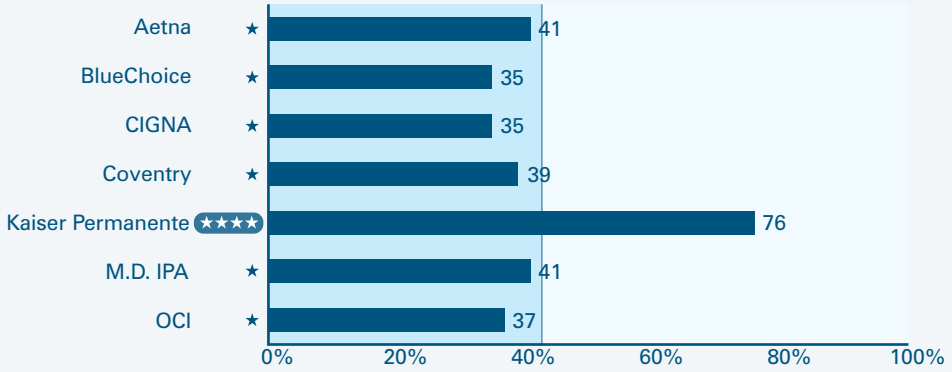
Screening for Breast Cancer
The percentage of women ages 50–69 who had a mammogram in 2004 or 2005.

☐ MD Plan Average = 71%



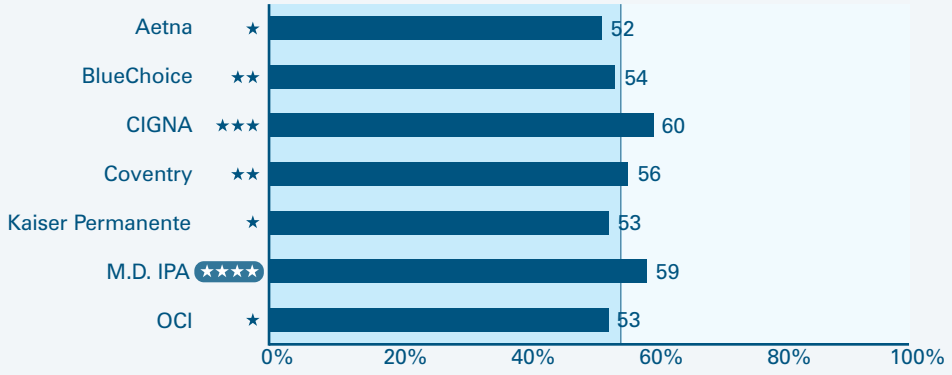
Screening for Chlamydia
The percentage of women ages 16–25 who received a test for chlamydia, a sexually transmitted bacterial infection.

☐ MD Plan Average = 43%



Screening for Colorectal Cancer
The percentage of adults ages 50–80 who received a test that screens for colon cancer.

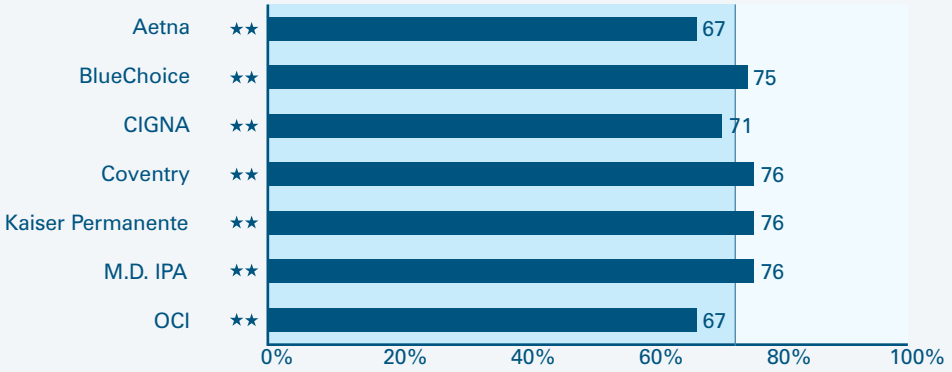
☐ MD Plan Average = 55%



Advising Smokers to Quit
The percentage of smokers 18 years of age and older who were seen by a provider in 2005 and received advice to quit smoking.

Data Source: Member Survey

☐ MD Plan Average = 73%



Chronic Care

MANAGING ONGOING MEDICAL PROBLEMS

If you already have a persistent (chronic) disease such as diabetes, having a health plan that provides quality services to manage the disease makes a difference. Doctors can control your diabetes by checking and controlling your blood sugar and cholesterol levels, making sure that you get routine eye exams, and testing your kidneys for kidney disease.

In 2005, 49 percent of Maryland plan members had a cholesterol level less than 100mg/dL and 72 percent had a cholesterol level less than 130mg/dL. In addition, 71 percent of plan members had their blood sugar (HbA1c) level controlled. Only 22 percent of Maryland plan members received comprehensive diabetes care, and the number varies widely between plans, from 15 percent to 43 percent. Looking at these numbers can help you decide which health plans can provide you quality diabetes care, if you or a loved one needs it.

Where does this information come from? For this group of members, each health plan checked its records to examine which members got the recommended service for managing certain chronic conditions. For example, the plans checked to see whether each member with diabetes got recommended regular eye exams.

Manage Your Health Care—How Aetna Helps Members with Diabetes Stay Healthy

Aetna's Healthy Outlook Diabetes Disease Management program has been in place since the early 1990s and remains a top priority. As of 2005, 7 percent of Aetna members in Maryland had diabetes, accounting for 62,000 doctor visits annually; it is first among all reported common chronic illnesses. Successful management requires frequent monitoring by physicians and patients to avoid complications including blindness and major organ failure. Implementation of the following activities showed overall improvements across diabetes measurements for each of the last three years:

- Use of detailed records and tools by Aetna clinical staff to track and flag the potential need for outreach.
- Physician education, including online classes, incentives for good performance, and charting tools and reminders about when patients need certain diabetes care and services.
- Member education that emphasizes ways to stay healthy, with schedules for monitoring important lab values and ongoing systems that send reminders to patients to come in for screenings.

This program is an example of how Aetna sought to address one quality of care issue in its program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.

The charts on this page summarize how well plans provided thier adult members with important health care services. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

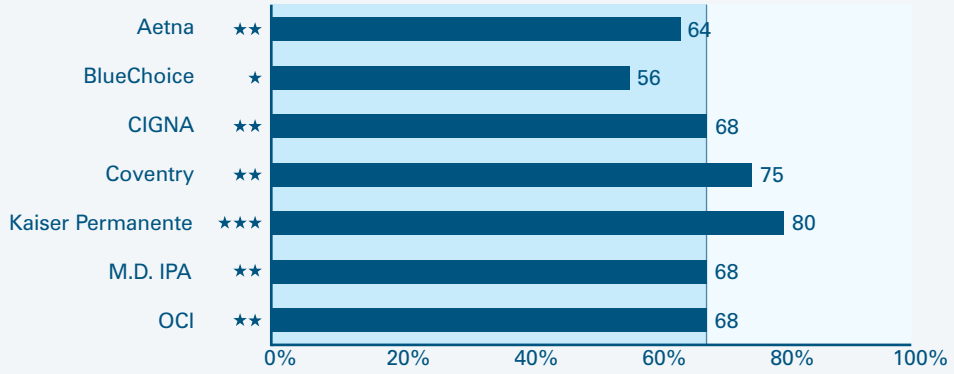
Performance

★★★★ Star Performer: Above Average for three years (2004–2006)
★★★ Above Average in 2006
★★ Average in 2006
★ Below Average in 2006

Stars show statistically significant differences between each plan's score and the Maryland average. "Statistically significant" means scores varied by more than could be accounted for by chance.

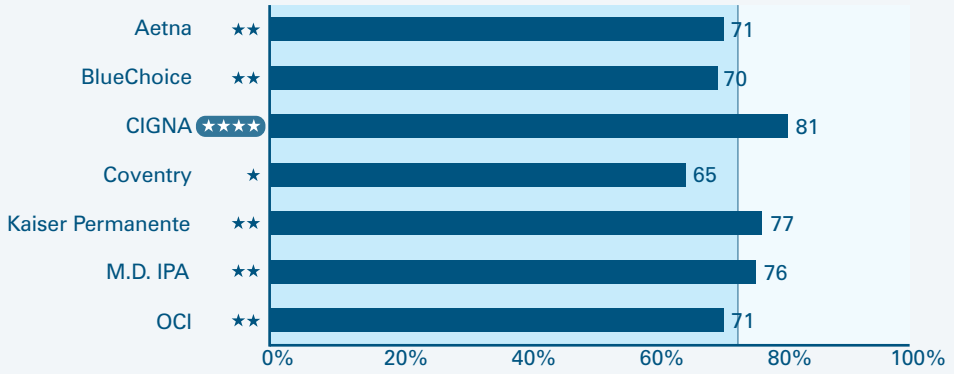
Persistence of Beta-Blocker Treatment after a Heart Attack
The percentage of members ages 35 and older who were hospitalized due to a heart attack and received a beta-blocker medication for six months after discharge.

☐ MD Plan Average = 68%



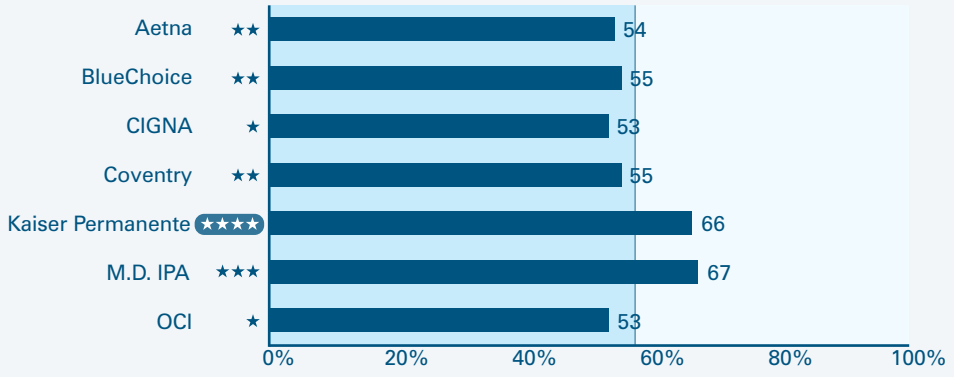
Controlling High Blood Pressure
The percentage of members with high blood pressure ages 46–85 who had controlled levels of pressure (no higher than 140mm Hg systolic and 90mm Hg diastolic) during 2005.

☐ MD Plan Average = 73%



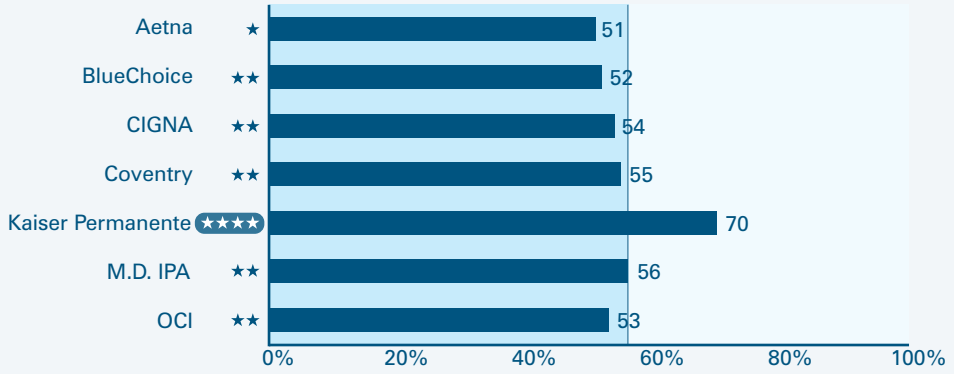
Eye Exams
The percentage of adult members with diabetes who had an eye screening for retinal disease in 2005 (or in 2004, if the retinal exam was normal).

☐ MD Plan Average = 57%



Monitoring for Kidney Disease (Diabetic Nephropathy)
The percentage of adult members with diabetes who were checked or treated for kidney disease, known as diabetic nephropathy.

☐ MD Plan Average = 56%



Behavioral Health Care

IMPROVING PRIMARY CARE PROGRAMS TO TREAT THE MIND AND THE BODY

The physical symptoms of mental illness or the occurrence of mental illness along with a physical condition can lead people to seek care from their primary care doctors for physical complaints. Often the primary care doctor is the first point of contact for a patient, giving the primary care setting an important role in identifying someone with an undiagnosed mental disorder.

In 2000, the U. S. Surgeon General met with consumers and experts to discuss ways to improve mental health care in the primary care setting. Barriers participants identified are:

- Lack of training for primary care providers to identify mental disorders and little guidance about when it is appropriate to treat disorder in the primary care setting
- Lack of sufficient time to treat mental disorders
- Lack of adequate funding from payers unsure about "integrated" programs.

When you feel you might be depressed, you should talk to your primary care doctor. Let your doctor know your symptoms and ask about what treatment options might work for you.

Where does this information come from? For this group of members, each health plan checked its records to examine which members got the recommended behavioral health service. For example, the plans checked to see whether each member who was diagnosed with depression took their prescribed antidepressant medication for the recommended amount of time.

Manage Your Health Care—How M.D. IPA and OCI Focus on Improving the Health of Members with Depression

Since 2004, M.D. IPA and OCI have offered a depression management program. The program helps patients with major depression learn the benefits of completing their cycle of treatment by offering them advice and information on treatment and recovery programs.

It has been shown that patients' symptoms are more likely to improve when their treatment lasts through the acute and continuous phases of therapy. To encourage them to complete both phases of therapy, patients receive educational materials that include information on symptoms, treatment, recovery, and prevention of a relapse. Printed materials are mailed to patients or are available on line. These include a log for monitoring medication side effects and an interactive form that identifies symptoms of depression, with coping mechanisms to reduce the symptoms. Patients may also receive case management services. Since the program began, the percentage of patients completing both the acute and continuous phases of antidepressant medication therapy has increased.

This program is an example of how M.D. IPA and OCI sought to address one quality of care issue in their program. The Commission takes no position on the claimed motivations, methodologies, or results of this quality initiative.

The charts on this page summarize how well plans provided behavioral health services to their members. Bar graphs show plan scores and performance for each area. More stars mean better plan performance.

Data Source: Health Plan Records

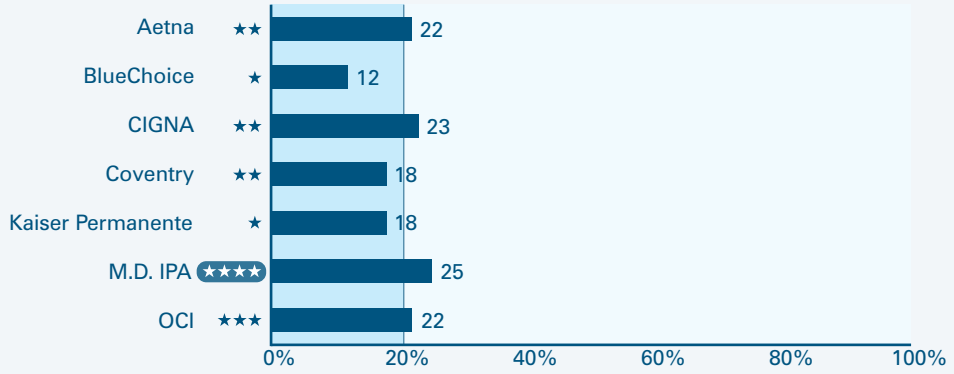
Performance

★★★★ Star Performer: Above Average for three years (2004–2006)
★★★ Above Average in 2006
★★ Average in 2006
★ Below Average in 2006

Stars show statistically significant differences between each plan's score and the Maryland average. "Statistically significant" means scores varied by more than could be accounted for by chance.

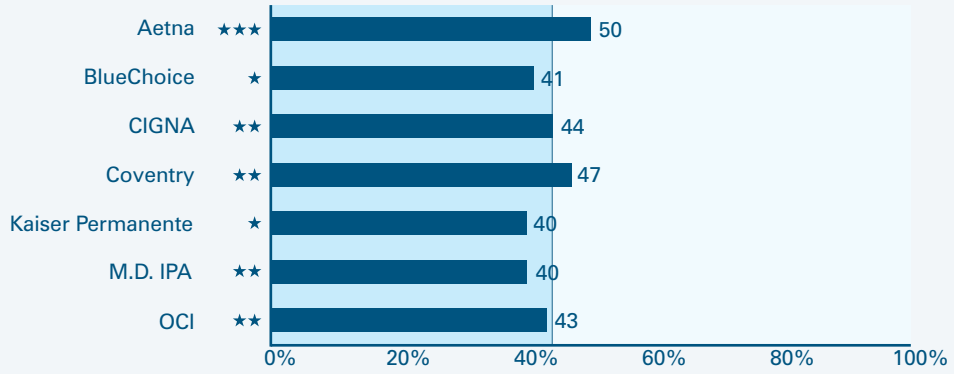
Antidepressant Medication Management
The percentage of members who saw a primary care or mental health practitioner at least three times within the first three months of being diagnosed with depression.

☐ MD Plan Average = 20%



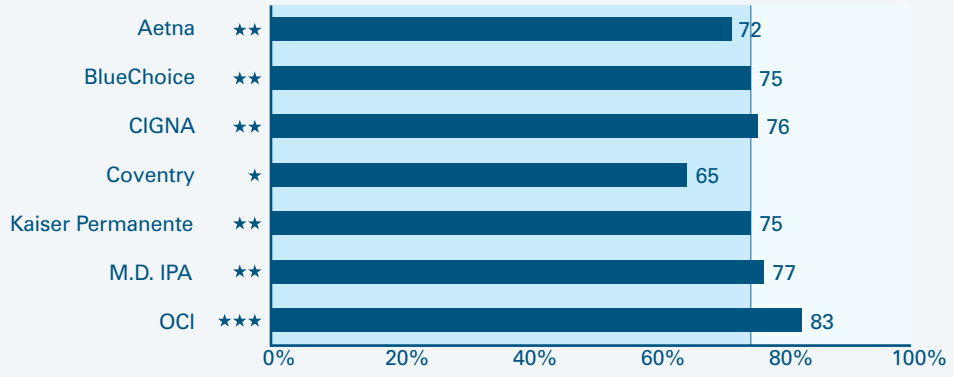
Antidepressant Medication Treatment
The percentage of members diagnosed with depression who took their antidepressant medication for at least six months.

☐ MD Plan Average = 44%



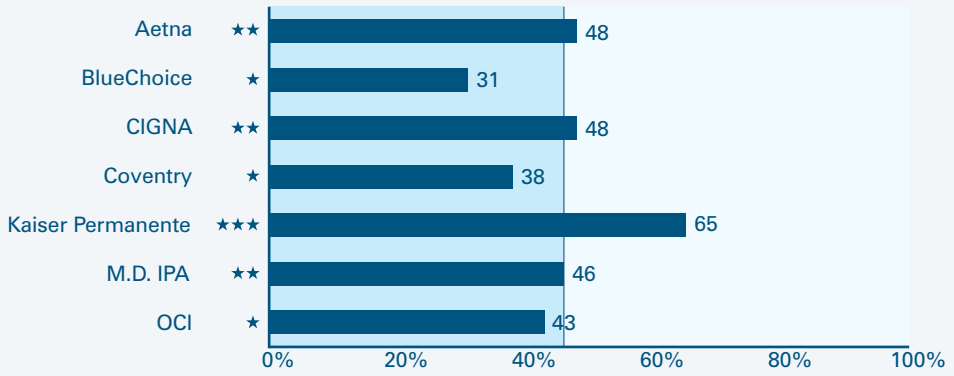
Follow-Up After Hospitalization
The percentage of members ages 6 and older who were hospitalized for a mental disorder and were seen at least once by a mental health provider within 30 days of leaving the hospital.

☐ MD Plan Average = 75%



Initiation of Alcohol and Other Drug Treatment
The percentage of members with alcohol or other drug dependence who started treatment through an inpatient admission or outpatient services within 14 days of diagnosis.

☐ MD Plan Average = 46%



Other Useful Information

GETTING CARE WHEN YOU ARE TOO SICK TO COMMUNICATE

An accident or illness can take away your ability to make health care choices. You can take steps now to make sure your wishes are carried out if this happens by creating a set of instructions known as an "advance directive." An advance directive lets you choose someone you trust to make health care decisions for you if you cannot, and documents your treatment wishes, particularly about treatments needed to keep you alive.

You can choose anyone who is 18 or older and who is not involved with the health care facility where you are receiving care. You can prepare by talking to your doctor, hospital, or nursing home, and family or friends who you want to know about your wishes. For more information on advance directives and your rights under Maryland law, go to Maryland's Web site at **http://www.oag.state.md.us/healthpol/AdvanceDirectives.htm**

INSURANCE COMPLAINTS AND APPEALS

You have the right to disagree and ask your health plan to change a decision to deny, limit, or not cover a medical service. This is called a "grievance." You can also ask a government agency to decide if the plan's final decision is fair (a "complaint"). The type of plan you have makes a difference in what steps you should take. Ask your employer which type of plan you are enrolled in.

Fully-Insured Health Plans—State Regulated

Under this type of plan, your employer buys health coverage through a licensed insurance company, which includes HMOs and POS Plans. Maryland regulates these plans. You can find out more information about filing a grievance by contacting the Consumer Protection Division of the Maryland Attorney General's Office at 1-877-261-8807. To file a complaint, call the Maryland Insurance Administration at 800-492-6116.

Self-Insured Health Plans—Federally Regulated

Under this type of plan, your employer pays for your health care costs out of a fund that the company has set aside for medical care. A federal law known as ERISA regulates these plans. You may file an appeal to the U.S. Department of Labor (call 866-4-USA-DOL) regarding problems that cannot be resolved with your plan or obtain assistance from a mediator from the Consumer Protection Division of the Maryland Attorney General's Office (1-877-261-8807).

PERFORMANCE REPORTS

For an electronic version of this Guide and additional information on health plan quality and performance, visit the MHCC Web site at **http://mhcc.maryland.gov/consumerinfo/**.

- *Measuring the Quality of Maryland HMOs and POS Plans: State Employee Guide*. Contains similar information as this Guide, but covers only HMO and POS plans available to employees of the State of Maryland.
- *Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland*. Contains more plan-specific rates on HEDIS (clinical) and CAHPS (survey) measures.
- *Maryland Commercial HMOs & POS Plans: Report to Policy Makers*. Compares the performance of commercial HMOs and POS plans in Maryland, as a group, to their counterparts in the region and nation.

Publications on the performance of health care facilities are available on the MHCC Web site at **http://mhcc.maryland.gov/consumerinfo/**, including these three Web-based, interactive Guides:

- *Maryland Hospital Performance Evaluation Guide*. Compares the quality of care provided by Maryland hospitals.
- *Maryland Nursing Home Performance Evaluation Guide*. Compares comprehensive nursing care facilities and continuing care retirement communities in Maryland on age or functional ability of residents and on measures of quality.
- *Maryland Ambulatory Surgery Facility Consumer Guide*. Compares descriptive information about ambulatory surgery facilities and their services.

Information for Employers

HEALTH CARE TRENDS

Nationally, health care premiums increased an average of 9.2 percent in 2005, down from the 11.2 percent average in 2004. With the rate of increase of health care costs outpacing that of growth in wages and other business expenses, more employers are stepping up their cost-containment efforts. Employer strategies range from educational efforts to creative cost sharing methods.

Educating employees on becoming better health care consumers

Employees may not realize that how they use the health care system affects health care cost. Some employers are using educational initiatives to inform their employees about how to navigate the system at a lower cost; for example, choosing a generic over a brand-name drug, seeing a primary care provider instead of a specialist, or using an urgent care center instead of a hospital emergency room.

Promoting employee health

Employees whose medical conditions are well managed are more productive and absent less often than employees whose medical conditions are poorly controlled. The Commonweatlh Fund (2005) reports that absenteism and "presenteism" cost U.S. employers $260 billion in 2003. In an effort to promote employee wellness, some employers offer health promotion programs. Some include onsite fitness programs; full or discounted membership to gyms; and even financial rewards for exercising, dieting, and other "good" health behaviors.

Employee cost-sharing

Some employers are targeting cost-sharing strategies at employees who practice unhealthy behaviors (e.g., smoking) in an effort to improve health and lower health care costs. The estimated additional premium that employers charge employees who smoke ranges, on average, from $20 to $50 a month. The National Business Group on Health (**http://www.wbgh.org/**) estimates that employees who smoke add an additional $3,856 a year to a company's health care costs.

Another method of cost sharing is consumer-driven health plans (CDHP), where employees are given a fixed amount of money to pay for their health care. After the money is spent, employees are responsible for their health care bills until they have paid a deductible. In 2006, 28 percent of 434 companies surveyed offered CDHPs, up from 22 percent in 2005 (Aon Consulting and the International Society of Certified employee Benefit Specialist, 2006). Of the companies that did not offer a CDHP option, 40 percent said that they were planning to introduce one.

Since July 1, 2004, the Comprehensive Standard Health Benefit Plan (a program offered to small businesses in Maryland) has been offering a type of CDHP that combines a high deductible PPO product with a Health Savings Account (HSA). Effective July 1, 2006, CDHP offerings available through this program were expanded to include a high deductible HMO accompanied by a Health Savings Account.

Health Information Technology

Health information technology (HIT) is broadly thought of as using computers to store, retrieve, and share healthinformation, data, and other information needed for decision-making purposes. Concerns about preventable medical errors, inconsistency in the quality of care, and fragmented communication among health care providers involved in treating patients have all emerged as key drivers toward wider adoption and use of HIT.

Electronic medical records contain medical information that, when authorized by the patient, can securely bridge information sharing between health care providers, and create the possibility of patients not needing to fill out any forms when arriving at a physician's office or hospital.

Interest is growing among many health care providers and consumers because of the potential efficiencies. Electronic medical records contain confidential patient information ranging from name and address to a patient's medical history.

Achieving the promise of a more efficient and effective health care system requires more than simply acquiring technology, and applying it to existing processes and practices. Employers have historically played a significant role in reshaping the health care system, and they can encourage—and leverage—the use of HIT to achieve lower costs and better care. Healthier employees cost less to insure. Large organizations such as Dell, IBM, General Motors, Kodak, and Kaiser Permanente have taken the lead in using HIT to enable employees to take greater responsibility for their own health care by securely maintaining an electronic record of their health information.

ABOUT THE MARYLAND HEALTH CARE COMMISSION (MHCC)

The MHCC is a public, regulatory commission appointed by the Governor with the advice and consent of the Maryland Senate. A primary charge of the Commission is to evaluate and publish findings on the quality and performance of commercial HMOs, nursing homes, hospitals, and ambulatory surgery facilities that operate in Maryland. MHCC produces this Guide annually with the cooperation of Maryland HMOs and their members. These annual performance reports are the only source of objective, independently audited information on the quality of Maryland commercial HMOs. More information about MHCC and performance reports is available at **http://mhcc.maryland.gov.**

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